

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / HOME HEALTH THERAPY ATTACHMENT (PA/HHTA)

Providers may submit prior authorization requests by fax to Wisconsin Medicaid at (608) 221-8616; or, providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088.

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization/Home Health Therapy Attachment (PA/HHTA) Completion Instructions (HCF 11044A).

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)

2. Age — Recipient

3. Recipient Medicaid Identification Number

SECTION II — PROVIDER INFORMATION

4. Name and Credentials — Therapist

5. Therapist's Medicaid Provider Number

6. Telephone Number — Therapist

7. Name — Referring / Prescribing Physician

8. Referring / Prescribing Physician's Medicaid Provider Number

SECTION III — DOCUMENTATION

9. Provide a Brief History Pertinent to the Service(s) Requested

10. Provide a Description of the Recipient's Diagnosis and Problems As They Pertain to the Need for the Therapy Services Requested (Include the date of onset)

SECTION III — DOCUMENTATION (Continued)

11. State Therapy History (Indicate type / date / location for all types of therapy)

Service Area	Location	Date	Problem Treated
Physical Therapy			
Occupational Therapy			
Speech and Language Pathology			

12. Indicate the Date of Initial Evaluation (Supply dates / tests used / results of additional evaluations)

13. Describe Progress in Measurable / Functional Terms Since Treatment Was Initiated or Last Authorized

14. Attach a Plan of Care Indicating Specific, Measurable Goals and Procedures to Meet Those Goals

15. Describe Rehabilitation Potential

16. **SIGNATURE** — Requesting Provider

17. Date Signed
